

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8229

| | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|
| BIRTH NO. | | REG. DIST. NO. 115 | | PRIMARY REG. DIST. NO. 4187 | | Registrar's No. | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Franklin</u> b. CITY (If outside corporate limits, write RURAL and give township) <u>Union</u> c. LENGTH OF STAY (in this place) <u>3 1/2 yrs</u> d. FULL NAME OF HOSPITAL OR INSTITUTION | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Franklin</u> c. CITY (If outside corporate limits, write RURAL and give township) <u>Union</u> d. STREET ADDRESS (If rural, give location) <u>0360</u> | | | | | |
| 3. NAME OF DECEASED (Type or Print) | | a. (First) <u>AMANDA</u> | | b. (Middle) <u>CATHERINE</u> | | c. (Last) <u>HORSEFIELD</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u> | | 8. DATE OF BIRTH <u>OCT. 28, 1858</u> | | | |
| 9. AGE (In years last birthday) <u>91</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life; if retired) <u>Housewife</u> | | 11. BIRTHPLACE (State or foreign country) <u>Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13a. FATHER'S NAME <u>Joseph McDaniel</u> | | 13b. MOTHER'S MAIDEN NAME <u>Margaret Mayfield</u> | | 14. NAME OF HUSBAND OR WIFE <u>Robert G. Horsefield</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT'S SIGNATURE OR NAME <u>Russell Horsefield, St. Louis, Mo.</u> | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Senility</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) <u>—</u> DUE TO (c) <u>—</u> II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. 19a. DATE OF OPERATION <u>—</u> | | | | 19b. MAJOR FINDINGS OF OPERATION <u>—</u> | | | | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>No</u> | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u> | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>—</u> | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <u>—</u> | | | | | |
| 22. I hereby certify that I attended the deceased from <u>10:31</u> to <u>3-17</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>3-17</u> , 19 <u>50</u> , and that death occurred at <u>7 P.M.</u> , from the causes and on the date stated above. | | | | | | | | | |
| 23a. SIGNATURE <u>H. L. Lenny</u> (Degree or title) <u>M.D.</u> | | | | 23b. ADDRESS <u>Union Mo</u> | | 23c. DATE SIGNED <u>3-20-50</u> | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>3-20-50</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>F.O.O.F.</u> | | 24d. LOCATION (City, town, or county) (State) <u>St. Clair, Mo.</u> | | | |
| DATE REC'D BY LOCAL REG. <u>Mch. 20-1950</u> | | REGISTRAR'S SIGNATURE <u>F.T. Cooper, Edna Cooper</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Casey & Russell, St. Clair, Mo.</u> | | | | | |

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
MAR 29 1950
District Health Officer
District File Number

MAY 2 1956

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed

David Russell

Licensed Embalmer No. *4520*

P. O. Address *St Clair, Me*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.